

Moving from Volume-Based to Value-Based Payment

Ideas for Increasing Oversight of Quality Performance
and Access to Care



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The Shift from Volume to Value

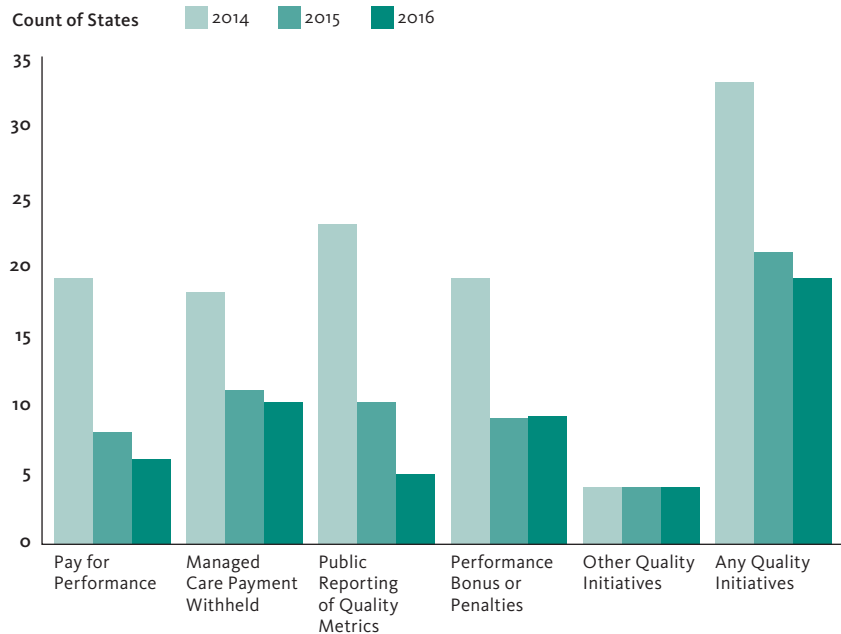
The Centers for Medicare and Medicaid Services (CMS) plans for Medicare Advantage to transform reimbursement methodologies to a model based primarily on value rather than volume. The current plan is to make payment 85 percent valued-based in 2016 and increase to 90 percent by 2018. CMS is encouraging state Medicaid programs to follow suit.

Current State Examples

The State of New York is leading the charge with its Delivery System Reform Incentive Payments (DSRIP) program. This initiative has a lofty goal for implementing a 100 percent value-based payment system in five years. By the fifth year, all outcome measures will be based on population health and clinical improvement outcomes instead of process measurements.¹

Other states are taking up the challenge from CMS to implement measures that drive reimbursements based on the value delivered by healthcare services. For example, the Kaiser Family Foundation recently completed its annual survey of Medicaid directors. The results show a major investment underway in value-based purchasing for managed care (MC) plans and continuing over the next two years. In FY 2015, 21 states implemented new or expanded quality initiatives; 19 states plan to in FY 2016. These include public reporting of quality metrics, pay-for-performance, capitation withholds, performance bonuses or penalties, quality initiatives, and performance improvement projects.² You can find more details in this chart.

States with Managed Care Quality Initiatives



Source: Smith, V., Gifford, K., Ellis, E. (2015). Medicaid reforms to expand coverage. Control costs and improve care: Results from a 50-state Medicaid budget survey for state fiscal years 2015 and 2016. Washington, DC: Kaiser Family Foundation.

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The Effect of Managed Care Growth

Over time, Medicaid has steadily expanded its use of managed care. Today, more than half of all Medicaid beneficiaries receive all or most of their care from MC plans; yet MC only accounts for 28 percent of spending. Given that three-fourths of inpatient expenditures remain fee-for-service (FFS), programs should take action to apply these same MC quality initiatives to FFS. Quality measurement initiatives can combine MC encounter data with FFS claims data to accomplish comprehensive oversight. (For example, Conduent studies on complications and readmissions for Texas Medicaid combined fee-for-service claims with MC encounter data and laid the foundation for pay-for-performance for Texas Medicaid providers.³)

Quality Measures: Where to Start?

As of December 2015, the National Quality Measures Clearinghouse listed 1,279 quality measures, most of them relating to health practices and processes.⁴ Indeed, there is growing concern among healthcare policy experts that these measures “are proliferating at an astonishing rate,” causing confusion, cost and lack of focus.⁵ Leaders in the quality movement have called on payers to “align with other payers on a smaller required set of high-impact and outcome-oriented measures.”⁶ The question is where to start to achieve the greatest quality improvement while using a state’s given resources for oversight of quality performance and access.

Medicaid pays for about 20 percent of all hospital stays nationwide, but its share is closer to half for obstetric, pediatric and newborn care. The Medicaid share for adult mental health is 25 percent and higher still for particularly vulnerable patients. Medicaid also covers more than 40 percent of stays for HIV/AIDS, sickle cell anemia, asthma and congenital heart defects.⁷ Clearly Medicare’s focus on only three conditions for readmission – heart failure, heart attack, and pneumonia – does not suit a Medicaid population.

Kevin Quinn, Vice President of the Payment Method Development group at Conduent, prefers a clinically meaningful casemix adjusted categorical model as a foundation for quality measurement. “A rate-based, value-based payment approach has a broader impact for a Medicaid population. The Medicaid approach cannot be limited to just the three conditions for readmissions that Medicare focuses on. There are numerous examples across the nation of improved outcomes, which lead to lowered costs. These methodologies can be applied in your state whether you are predominantly MC or a combination of MC and FFS.”

Building an Effective Foundation

Even if you have not yet started, you can establish a foundation for pay-for-performance during 2016. Start by compiling your claims and encounter data for analysis. This data can then be run through clinically sophisticated, established algorithms to create a report you can use as the basis for your pay-for-performance program. We recommended statewide performance as a commonsense starting point to set benchmarks. Hospital-specific data is compared to benchmarks and then shared with hospitals (subject to a minimum claim volume), so they can take necessary action to monitor, conduct root cause analysis and improve their performance.

Meanwhile, states should develop a strategy for implementing and rolling out value-based purchasing. Pay-for-performance can be accomplished in a budget-neutral environment, but Medicaid agencies must first consider key questions from a variety of perspectives. How will value-based payment be structured, paid – and to whom? How can patient experience be measured? And how will the agency's role change?

How Conduent Can Help

Conduent has performed similar analyses for several states. Our experienced payment method consultants and statisticians can help you design and implement a pay-for-performance program three months to six months after the compiling the data. Visit conduent.com/medicaid for more information about how we develop payment strategies.

Sources

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5. Blumental, D., & McGinnis, J.M. (2015). "Measuring Vital Signs: An IOM Report on Core Metrics for Health and Health Care Progress." *Journal of the American Medical Association*, 313(19), 1901-1902.
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